STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155243	A. BUILDING _____ B. WING _____	C 02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANS CARE AND REHAB-GREATER LAFAYETTE	300 WINDY HILL DR LAFAYETTE, IN 47905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00102112 and IN00102602. Complaint IN00102112 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00102602 - Substantiated. No deficiencies related to the allegations are cited. Survey Dates: 2/01/12 and 2/02/12 Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900 Survey Team: Heather Lay, RN - TC Janet Stanton, RN Melanie Strycker, RN Census Bed Type: SNF/NF: 132 Total: 132 Census Payor Type: Medicare: 25 Medicaid: 76 Other: 31 Total: 132 Sample: 07 Kindred Trans Care and Rehab - Greater Lafayette was found to be in compliance with 42 CFR Part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00102112 and IN00102602.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality review 2/03/12 by Suzanne Williams, RN	F 000		